

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005044	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/14/2014
NAME OF PROVIDER OR SUPPLIER REID HOSPITAL & HEALTH CARE SERVICES		STREET ADDRESS, CITY, STATE, ZIP CODE 1100 REID PKWY RICHMOND, IN 47374		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>This visit was for the investigation of a State complaint.</p> <p>Complaint: IN00132551 Unsubstantiated, lack of sufficient evidence.</p> <p>Date of Survey: 03-14-14</p> <p>Facility number: 005044</p> <p>Surveyor: John Lee, R.N. Public Health Nurse Surveyor</p> <p>Reid Hospital & Health Care Services is in compliance with 410 IAC 15-1.6-2, Emergency services, Hospital Licensure Rules.</p> <p>QA: cloughlin 03/31/14</p>	S 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE